STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		155697	B. WIN			09/18/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	L			ITTLE LEAGUE BLVD		
CLARK R	REHABILITATION A	ND SKILLED NURSING CENTER	₹		SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000							
	TEL: ::/ C	T	F00	00			
		r Investigation of	F00	00			
	Complaint IN00	115675.					
	Complaint INO	115675 - Substantiated -					
	•	iciencies related to the					
		ited at F250, F279, 309,					
	319, 322, and F5	514.					
	Survey dates: So	eptember 17 and 18, 2012					
	Facility number:	000059					
	Provider number	:: 155697					
	AIM number: 1						
	Survey team: G	loria J. Reisert MSW					
	Census bed type	-					
	SNF: 5	•					
	SNF/NF: 65						
	Total: 70						
	Census payor typ	ne:					
	Medicare: 10	r - ·					
	Medicaid: 49						
	Other: 11						
	Total: 70						
	Commiss (						
	Sample: 6						
	These deficienci	es reflect state findings					
		nce with 410 IAC 16.2.					
	cheu ili accordal	ice with 410 IAC 10.2.					
LABORATOR	Y DIRECTOR'S OR PROV	VIDER/SUPPLIER REPRESENTATIVE'S SIG	GNATURI	<b></b> E	TITLE		(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

000059

PRINTED: 10/17/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155697		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY  COMPLETED  09/18/2012			
	PROVIDER OR SUPPLIER	NO SKILLED NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 517 N LITTLE LEAGUE BLVD				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
IAU	Quality review com Cathy Emswiller R	pleted 9/24/12	IAG		DATE		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PWVR11

Facility ID: 000059

If continuation sheet Page 2 of 34

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155697	B. WIN			09/18/	2012
			D. 1/11.1	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ITTLE LEAGUE BLVD		
CLARK R	REHABILITATION A	ND SKILLED NURSING CENTER			SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0250 SS=D	SOCIAL SERVIC The facility must proceed to highest practicable psychosocial well based on record facility failed to social services to who was having the facility (Residensure the family)	attain or maintain the le physical, mental, and being of each resident. review and interview, the provide medically related assist a new resident difficulty in adjusting to dent #E) and failed to was fully informed of	F02	50	What corrective actions will be accompliashed for those residnets found to have been affected by the alleged deficien practice? Resident "E" care plates been updated to reflect adjustment issues with interventions including psych.	nt	10/12/2012
	resident's health ramifications.(Ro deficient practice	te health status and the care choices and their esident #A). This e affected 2 of 6 residents cial Services in a sample			interventions including psych services visit and incorporation previous activity interests. So services has met with resident to assist resident in adjustmen facilitySocial Services has met with resident A and resident's family durina a care plan meet to discuss wishes for future treatment in relation to her	cial E t to ing	
	1. Review of the clinical record for Resident #E on 9/18/2012 at 9:45 a.m., indicated the resident was admitted to the facility from another nursing home on 8/4/2012 and had diagnoses which included, but were not limited to: vascular dementia with disturbance of mood and behavior, panic disorder without agoraphobia, anxiety, gastrostomy tube placement, dysphagia and hemiplegia.  Review of the nursing notes between				feeding tube and other advance directives. The residents care plan has been updated to reflether families wishes. How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken. Residents experiencing behaviors at the facility have the potential to be affected by the alleged deficient practice. All st will be re-educated on the facil behavior program including ho to appropriately communicate regarding a behavior by 10/10/by SSD/designee. Post test included. Residents expressing	ect ou the ne aff lity w	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PWVR11

Facility ID: 000059

If continuation sheet

Page 3 of 34

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		DDIG	00	COMPLETI	ED
		155697	A. BUII			09/18/20	12
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	ND SKILLED NURSING CENTER		CLARK	SVILLE, IN 47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		OMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	'	DATE
	8/4/2012 and 9/1	8/2012 indicated the			desire to re evaluste their		
	following entries				advanced directives have the		
					potential to be affected by the		
		0:00 a.m Res (resident)			alleged deficient practice. Soc		
		rful this am crying loudly			services director will be educa		
	and asking for da	aughter saying 'I want out			by the social services consulta		
	of here!! This is:	n't what I though it was			by 10/10/12 for how to identify		
	going to be'"				and address residents advanc directive needs. All residents	eu	
					have been reviewd for change	s in	
	_ "8/9/2012 at 2:	06 p.mNot as tearful			condition that may warrant	·	
		oo p.mvot as tearrai			discussions regarding advance	ed	
	today"				directive wishes.What measure		
					will be put into place or what		
	- "8/14/2012 at 6	5:45 p.m Res in room			systemic changes you will mal	ке	
	crying and sayin	g she was going to die.			to ensure that the deficinet		
	Said she saw the	tunnel and she was			practice does not recur?All sta		
	going to die Las	sured her she wasn't			will be re-educated on the facil	-	
	going to die"	Saled her she wash t			behavior program including ho	W	
	going to dic				to appropriately communicate		
					reagarding a behavior by 10/10/12 by the		
		2:22 a.m Res abed.			SSD/designee.Residents with		
	Sleeping most of	f shift. When res woke			behavioral issues will have a c	are	
	she up she was v	ery confused. Said she			plan developed with the		
	was very tired ar	nd wanted to know if she			interventions to assist in		
	1	. I assured her she was			managing the behavioral		
		She also was stating her			issue.New or worsening		
		C			behaviors will be reviewed by	the	
	•	arms. She was then			IDT Monday through Friday,		
	_	ickey Mouse doll beside			weekends will call the on-call		
	her on the bed. S	he told him to shut up. I			nurse to assess cause, and	_	
	asked her if Mic	key was talking to her			update interventions to decrea cause.IDT reviews will include		
		that he said he was in			assessment of potential medic		
	pain too"	- · · · · · · · · · · · · · · · · · · ·			contributors, root cause and	-ui	
	Puin 100				preventative intervention.Socia	<sub>al</sub>	
	D . 0.1 ~	. 10			services will meet with rsidents		
	Review of the Social Service				who are having adjustment		
	documentation b	etween 8/4/2012 and			difficulties and develop		
	9/18/2012 indica	ited a note dated			interventions to address		
	8/10/2012 which	addressed an Admission			adjustment.IDT will review		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PWVR11

Facility ID: 000059

If continuation sheet Page 4 of 34

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DING	00	COMPL	ETED
		155697	A. BUII		<u> </u>	09/18/	/2012
			B. WIN	_	DDDECC CITY CTATE 7TD CORE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIE	R		1	ADDRESS, CITY, STATE, ZIP CODE		
<b>.</b>					ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION /	AND SKILLED NURSING CENTER	2	CLARK	SVILLE, IN 47129		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	-	DATE
	Assessment on	the resident's cognition,			interventions and progress to		
	hearing, vision,	communication skills and			residents adjustment.IDT will		
	_	It also addressed the			review changes (including nev		
					worsening behavior) for need	to	
		be seen by the psychiatrist			address advanced directive		
		nage psychiatric diagnoses			wishes. Social services/desig		
	and medications	S.			will inform families of behavio		
					changes or changes in condit IDT will ensure that notificatio		
	A second note d	lated 8/15/2012 indicated			complete per medical record	11 13	1
		s evaluated by the			review. Residents/families wi	ll be	
					contacted by social services	50	1
		his date per staff and			director or designee for a care	)	
		st due to poor appetite and			plan meeting to address.	-	
	tearfulness at tir	nes.			Residents/families will also be	;	
					invited to care plan meetings	on a	
	Documentation	was lacking in which the			quarterly basis or change in		
		addressed the resident's			condition during which advan		
					directives will be reviewed by	the	
		djusting to placement,			IDT.Social services/designee		
	thoughts of dyir	ng and auditory			respnsible for		
	hallucinations.				complianceNon-compliance w		
					result in re-education includio	ng	
	   During an inters	view with the Social			disciplinary actionHow the corrective actions will be		
	_				monitored to ensure the defici	ont	1
		/2012 at 4:25 p.m., she			practice will recur,.e., what qu		
		as not aware the resident			assurance program will be pu	-	
	had made the sta	atements of thinking she			into place The Psychoactive		
	was dying, not a	adjusting to placement,			Medications/Behavior		
		of auditory hallucination			management CQI tool will be		
	•	ve addressed the issues as			utilized weeklyx4, then month	ly	
					thereafter by the SSD or	-	
	_	sure the psychiatrist was			designee for six months. Data	а	
	also aware.				will be submitted tot he CQI		
					committee for review and		
	She indicated th	at she usually she would			follow-upThe care plan review	1	1
		norning meetings if the			CQI audit tool will be utilized		
		naving issues and that the			weekly x4, then monthly		
		_			thereafter by the SSD or	_	
		out behavior sheets			designee for six months. Data	a	
	whenever an iss	ue like the statements of			will be submitted tot he CQI		1

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155697	B. WIN	G		09/18/2012
NAME OF B	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	KOVIDEK OK SUITELEN			517 N L	ITTLE LEAGUE BLVD	
CLARK F	REHABILITATION A	ND SKILLED NURSING CENTE	R	CLARK	SVILLE, IN 47129	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	1 2 0	out that she had put into			committee for review and follow-upFindings from the CQ	.
	1 1	tem in the computer at the			process will be reviewed mont	
	_	or Behavior Monitoring in			and an action plan will be	,
	which the staff e	nter an event occurrence,			implemented for threshold belo	ow
	and then it would	d create a report she			95%.	
	could review eve	ery morning. The Social				
	Worker also indi	cated that because the				
	staff were still tr	ying to get used to her				
	new system, she	was still not always				
	getting reports o	f issues.				
	2. Review of the	clinical record for				
	Resident #A on	9/17/2012 at 11:10 a.m.				
		ident was re-admitted				
		l on 5/18/2012 and had				
	-	included, but were not				
		agia, diverticulosis and				
	dementia.	lagia, diverticulosis and				
	dementia.					
	Review of the M	lay 2012 nursing notes				
		re not limited to the				
	following entries					
	_	:50 p.m Res discharged				
	to [name of hosp					
	placement."	maij idi g-tude				
	piacement.					
	_ "5/4/2012 at 4:	41 p.m pt [patient]				
		I new g-tube out of				
		hift and site was bulging				
	_					
		AD notified and family				
	1 *	ent to [name of hospital]				
		room] for evaluation of				
	site and placeme	nt"				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PWVR11

Facility ID: 000059

If continuation sheet Page 6 of 34

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155697		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	COM	TE SURVEY MPLETED 18/2012	
	PROVIDER OR SUPPLIEI	I R AND SKILLED NURSING CENTE	STREET 517 N I	ADDRESS, CITY, STATE, ZIP LITTLE LEAGUE BLVD (SVILLE, IN 47129		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	to the hospital u	s subsequently admitted ntil 5/18/2012 when she n/g tube [nasogastric].				
	removed NG tub New order recei with chest x-ray placementRes	5 p.m Resident be at 1300 [1:00 p.m.]. ved to replace NG tube to verify ident tolerated procedure				
	bed. Received re NG tube in stom bolus feeding an NG tube out. Sta Res agitated a	7:27 p.m Res resting in esults from x-ray. Showed nach. Went to give result meds. Res had pulled nated 'I don't want that in.' this time. Not allowing tube. Will attempt when				
	N/G tube out. [N phoned and noti	11:30 a.m Res. pulled Name of Physician] fied with new orders to obtain stat x-ray to verify I."				
	11:23 a.m. on 5/ removed and rep to difficulty in e positioned corre because the resid	p.m. on 5/24/2012 and 25/2012, the n/g tube was placed 3 more times due insuring the tube was ctly. At 11:23 a.m., dent was complaining of lineck, the physician gave				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PWVR11

Facility ID: 000059

If continuation sheet

Page 7 of 34

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	LTIPLE CO	NSTRUCTION	(X3) DATE S COMPL	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155697	A. BUILD		00	09/18/	
		100001	B. WING	_	ADDRESS, CITY, STATE, ZIP CODE	33/10/	
NAME OF P	PROVIDER OR SUPPLIER				ITTLE LEAGUE BLVD		
		ND SKILLED NURSING CENTE			SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	``	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		REFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION DATE
1710		the resident to be sent to		1710			DATE
		cation of tube placement.					
		the n/g tube had been					
	· ·	laced again to attain					
	proper placemen						
	proper placemen						
	- "5/28/2012 at 9	2:41 p.m Resident					
		e out of Nare [nose].					
		ied MD, N/O [new order]					
		be. N/O obtain x-ray via					
	[name of x-ray company] to verify						
	placement before resuming meds and						
	feedings stat [im	•					
	5 1	7.1					
	- "5/30/2012 at 6	5:01 p.m Upon entering					
	residents(sic) roo	om, resident had pulled					
	NG tube out of n	ose, notified MD of					
	issue. N/O X-ray	via [name of x-ray					
	company] to veri	ify placement of NG tube					
	STAT. Place NO	tube per policy"					
	On 5/31/2012 at	6:55 a.m., the resident					
	was transferred t	o the [specialist					
	physician] center	r for placement of a					
	g/tube.						
	During an interv	iew with LPN #1 on					
		05 p.m., she indicated the					
		ften say that "it hurt"					
	when referring to	the NG tube and that					
	she thought this	might have been the					
	reason for the res	sident pulling it out.					
	Review of the So	ocial Work					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PWVR11

Facility ID: 000059

If continuation sheet Page 8 of 34

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	MULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPLE 00/19/2	
		155697	B. WIN			09/18/2	2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
CLARK F	REHABILITATION A	ND SKILLED NURSING CENTE	₽R		ITTLE LEAGUE BLVD SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCI)		DATE
		or May 2012 included an					
	1 -	/2012 which described					
		t Change Minimum Data					
	Set [MDS] Asset						
		umentation was lacking in with the resident's family					
	·	discuss the incidents of					
		quent pulling out the NG					
		zing she did not want it in					
		what the family's wishes					
	were for future c						
	were for future c	arc.					
	During an interv	iew with the Social					
		2012 at 2:40 p.m., she					
		nily had been aware each					
		pulled the tube out and					
		ving difficulty getting it					
	back in the prope						
		e facility should have had					
		the family to discuss the					
		ole and of the resident					
		y she did not want the					
	tube.	,					
	During an interv	iew with the family on					
	9/17/2012 at 3:1	0 p.m., she indicated that					
	she was aware or	f the resident pulling out					
	the tube and of the	he need for an x-ray					
	which took a lon	g time, but was not aware					
	of how many tin	nes collectively it was					
	1	f how difficult it was for					
	the facility to rep	place it in the correct					
	1 .	licated that she was not					
	_	nt had told staff she did					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PWVR11

Facility ID: 000059

If continuation sheet Page 9 of 34

PRINTED: 10/17/2012 FORM APPROVED OMB NO. 0938-0391

	of correction identification number:  155697	(X2) MULTIPLE CO.  A. BUILDING  B. WING	00	COMPLETED  09/18/2012
	PROVIDER OR SUPPLIER REHABILITATION AND SKILLED NURSING CENTER	STREET A 517 N L	DDRESS, CITY, STATE, ZIP CODE ITTLE LEAGUE BLVD SVILLE, IN 47129	1
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
	not want it in and of it hurting her/ The family member indicated that all she had been told by the facility was that the resident had to have the tube to eat, so she tried to convince the resident to at least try the tube. She also indicated she only wanted the resident to be made as comfortable as possible and not be in pain.  On 9/18/2012 at 2:45 p.m., the Nurse Consultant presented a copy of the facility's current policy on "Care Plan review and Maintenance". Review of this policy at this time, included but was not limited to: " Care Plan Guidelines: Purpose: Create an organized meeting on a routine basis with the purpose of communicating with families and residents important information about the well being and needs of the resident in a meaningful way. Help develop stronger relationships with families and residents to improve care Change the social culture and encourage care plan meetings to focus on resident choices and preferences to enhance the resident's life."			
	On 9/18/2012 at 2:10 p.m., the Accounts Receivable Manager presented a copy of the Social Worker's signed Job Description dated 1/2/12. Review of the Job Description at this time included, but was not limited to:"Summary Of Position			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PWVR11

Facility ID: 000059

If continuation sheet

Page 10 of 34

PRINTED: 10/17/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION  OF CORRECTION  155697	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 09/18/2012
	PROVIDER OR SUPPLIER REHABILITATION AND SKILLED NURSING CENTER	517 N L	ADDRESS, CITY, STATE, ZIP CODE ITTLE LEAGUE BLVD SVILLE, IN 47129	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Functions: The Social Services Director provides medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Essential Position Functions: Assesses each resident's psychosocial needs and develops a plan for providing care. Reviews resident's needs and care plan with progress notes indicating implementation of methods to respond to identified needsProvides assistance to residents in adjusting to the facility, exercising their rights as residents"  This Federal tag is related to Complaint IN00115675.  3.1-34(a)			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PWVR11

Facility ID: 000059

If continuation sheet

Page 11 of 34

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	JLTIPLE CO	ONSTRUCTION 00	(X3) DATE S	
THID TEXEL	or condition	155697	A. BUIL			09/18/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ITTLE LEAGUE BLVD		
CLARK R	REHABILITATION A	ND SKILLED NURSING CENTER			SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
F0279	483.20(d), 483.20	LSC IDENTIFYING INFORMATION)  (k)(1)		TAG	Bertelekery		DATE
SS=D		PREHENSIVE CARE					
		e the results of the					
		evelop, review and revise					
	the resident's con	nprehensive plan of care.					
	care plan for each	develop a comprehensive					
		ctives and timetables to medical, nursing, and					
		nosocial needs that are					
		omprehensive assessment.					
	•	ist describe the services					
		hest practicable physical,					
	mental, and psycl	hosocial well-being as					
		183.25; and any services					
		rise be required under not provided due to the					
	•	e of rights under §483.10,					
		t to refuse treatment under					
	§483.10(b)(4).						
	Based on record	review and interview, the	F02	79	What corrective action(s) will be		10/12/2012
	•	develop care plans which			accomplished for those reside		
	addressed a new	resident's poor			found to have been affected by the deficient practiceResident	-	
	adjustment to the	e nursing home with			care plan has been reviewed a		
	beliefs of dying a	and auditory			updated to reflect adjustment		
	hallucinations (R	Resident #E); when a			issues with interventions include	ding	
	resident with an	NG tube continually			psych services visit and incorporation of previous activ	itv	
	pulled it out (Res	sident #A); when a			interests. Social Services has	•	
	resident was place	ced on fluid restrictions			met with Resident E to assist		
	and failed to list	additional interventions			resident in adjustment to the		
	necessary for the	e care of a dialysis			facility.Resident A no longer ha	as	
	•	nt #C). This deficient			the n/g tube but has a g-tube- residents care plan has been		
	`	3 of 6 resident reviewed			reviewed and updated to reflect	ct	
	•	a sample of 6 residents.			current plan of careResidents		
	3 P.W.D III	-r			care plan has been reviewed a		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PWVR11

Facility ID: 000059

If continuation sheet Page 12 of 34

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPLI	ETED
		155697	A. BUII			09/18/2	2012
			B. WIN		A DDDDGG GUTY GTA TO GID GODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
					ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	AND SKILLED NURSING CENTER	2	CLARK	SVILLE, IN 47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
	Findings include	-q.			updated to reflect current fluid		
	i mamga meraac	ou.			restrictions and dialysis		
					care/interventionsHow other		
					residents having the potential	to	
	1. Review of the clinical record for				be affected by the same defici	ent	
	Resident #E on 9	9/18/2012 at 9:45 a.m.,			practice will be identified and		
	indicated the res	ident was admitted to the			what corrective action(s) will b	е	
		other nursing home on			takenAll residents have the		
		•			potential to be affected by the		
		d diagnoses which			alleged deficient		
	· ′	ere not limited to: vascular			practicesLicensed nurses wer		
	dementia with d	isturbance of mood and			in-serviced on developing plar care for residents when	1 OT	
	behavior, panic	disorder without			completing a telephone order		
	agoraphobia an	xiety, gastrostomy tube			indicating a change of condition	n l	
	1	hagia and hemiplegia.			by the SDC/designee no later	"	
	piacement, dysp	nagia and nemplegia.			than 10/10/12. Post test		
					included.All staff will be re		
	Review of the m	ursing notes between			educated on the facility behav	ior	
	8/4/2012 and 9/1	18/2012 indicated the			program including how to		
	following entries	s:			appropriately communicate		
		0:00 a.m Res (resident)			reagarding a behavior by		
		rful this am crying loudly			10/10/12 by the SSD/designed		
	1				Post test included.Residents v		
	1	aughter saying 'I want out			behavioral issues will have a		
		n't what I though it was			plan developed with interventi	ons	
	going to be'"				to assist in managing the		
					behavioral issue. Social service		
	- "8/9/2012 at 2:	06 p.mNot as tearful			will meet with residents who a having adjusment difficulties a		
	today"	F			develop interventions to adres		
	way				adjustment. IDT will review	·	
	WO /1 4 /2 O 1 O	C 45			interventions and progress to		
		6:45 p.m Res in room			residents adjustment.100% au	ıdit	
	crying and sayin	ig she was going to die.			of all residents with fluid		
	Said she saw the	tunnel and she was			restrictions, G-tubes, and		
	going to die. I as	ssured her she wasn't			Dialysis and care plans were		
	going to die"				updated by DNS/designee-all	on	
	50mg to uic				or before 10/12/12Change of		
	#0/22/2012 = =				condition/adjustment to		
		7:22 a.m Res abed.			facility/residents recieving		
	Sleening most of	f shift When res woke	1		dialysis/new or readmitted		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			COMPLETED
		155697				09/18/2012
			B. WIN		ADDRESS CITY STATE ZID CODE	
NAME OF P	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE	
OL A DIV. E	SELLA DIL ITATIONI A	AND OKUL ED NUIDOINO OFNITED			ITTLE LEAGUE BLVD	
CLARK F	REHABILITATION A	AND SKILLED NURSING CENTER		CLARK	SVILLE, IN 47129	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	she up she was v	very confused. Said she			residents will be reviewed daily	, ,
	was very tired at	nd wanted to know if she			the IDT/unit manager to ensur	• • • • • • • • • • • • • • • • • • •
	was going to die. I assured her she was				care plan was updated to refle	
					residents condition.All carepla	ns
	1	She also was stating her			are up to date relating to poor	ا
	_	r arms. She was then			adjustment to facility, advance directives, dialysis and food/flu	
	_	ickey Mouse doll beside			restrictions.Non compliance w	
	her on the bed. S	She told him to shut up. I			result in further education	"
	asked her if Mic	key was talking to her			including disciplinary action	
		that he said he was in			DNS/designee is responsible t	o
	pain too"				ensure compliance with clinica	
	pain 100				care plansSSD/designee will b	e
	<b>.</b>	1 1: 6 1			responsible for compliance of	
		was lacking of a care plan			behavior programWhat measu	res
	by Social Servic	es which addressed the			will be put into place or what	
	resident's malad	justment to placement and			systemic changes will be made	
	decline in mood	with auditory			ensure that the deficient practi	
	hallucinations.	3			does not recurLicensed nurses were in-serviced on developing	
	nanachianons.				plan of care for residents when	
	Di :	.i			completing a telephone order	'
	_	view with the Social			indicating a change of condition	n
		/2012 at 4:25 p.m., she			by the SDC/designee no later	
		sident's poor adjustment			than 10/10/12. Post test	
	and mood issues	s could warrant a care plan			included.All staff will be	
	and that one pro	bably should have been			re-educated on the facility	
	written.	-			behavior program including ho	W
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				to appropriately communicate	
					regarding a behavior by the SSD/designee by 10/10/12. P	ost
	0 D : 04	1 1 . 1			test included.Social Services v	
		e clinical record for			educated on developing plan	
		9/17/2012 at 11:10 a.m.			care for any change in	"
	indicated the res	sident was re-admitted			psychosocial concerns with	
	from the hospita	ll on 5/18/2012 and had			residents by the SS	
	1	included, but were not			Consultant/designee no later t	han
	~	nagia, diverticulosis and			10/12/12. Post test	
	dementia.	ingia, diverneurosis and			included.100% audit of all	
	demenua.				residents care plans was	
					completed/updated by the	
	Review of the M	1 fay 2012 nursing notes			DNS/designee all on or before	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PWVR11

Facility ID: 000059

If continuation sheet

Page 14 of 34

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPLETED	
		155697	A. BUII B. WIN			09/18/2012	
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹			ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	AND SKILLED NURSING CENTER			SVILLE, IN 47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	included, but we	ere not limited to the			10/12/12Change of condition, admissions and		
	following entries	S:					
	- "5/1/2012 at 1:50 p.m Res discharged				re-admissions will be reviewed daily by the IDT/unit		
	to [name of hosp	oital] for g-tube			manager to ensure care plan v		
	placement."				completed as neededAll care		
	*				plans are up to date relating to		
	  - "5/4/2012 at 4·	41 p.m pt [patient]			poor adjustment to the facility,		
		l new g-tube out of			advanced directives, dialysis, a fluid/food restrictions.Non	and	
		hift and site was bulging			compliance will result in furthe	r	
	•	MD notified and family			education including disciplinar		
		3			action DNS/designee is	<b>,</b>	
		ent to [name of hospital]			responsible to ensure complia	nce	
		room] for evaluation of			with clinical care		
	site and placeme	ent"			plansSSD/designee will be	.h	
					responsible for compliance wit the behavior programHow the	n	
	The resident was	s subsequently admitted					
	to the hospital u	ntil 5/18/2012 when she			corrective action(s) will be monitored to ensure the deficient		
	returned with an	n/g tube [nasogastric].			practice will not recur, i.e., wha		
					quality assurance program will	be	
	- "5/19/12 at 2:3	5 p.m Resident			put into placeThe CQI tool for care planning will be utilized		
	removed NG tub	pe at 1300 [1:00 p.m.].			weekly x 4 weeks, monthly x 6		
		ved to replace NG tube			months and quarterly		
	with chest x-ray	•			thereafter.Findings from the C		
	_	ident tolerated procedure			process will be reviewed mont	hly	
	well"	racin toloratea procedure			and an action plan will be		
	,, 011				implemented for threshold below 95%	Jvv	
	_ "5/10/2012 at 3	7:27 p.m Res resting in			0070		
		esults from x-ray. Showed					
		asch. Went to give res					
		•					
		d meds. Res had pulled					
		nted 'I don't want that in.'					
	_	t this time. Not allowing					
	_	tube. Will attempt when					
	res calms down.	"					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PWVR11

Facility ID: 000059

If continuation sheet

Page 15 of 34

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP	LE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155697	A. BUILDING	ì	00	COMPL: 09/18/	
		100097	B. WING	DDT 4	A PARAGO CITTLE CONT.	03/10/	2012
NAME OF F	PROVIDER OR SUPPLIE	₹			ADDRESS, CITY, STATE, ZIP CODE		
CLARK F	REHABILITATION A	AND SKILLED NURSING CENTER			SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	ICY MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION)	TAG	J	DEFICIENCT)		DATE
		11:30 a.m Res. pulled					
	-	Name of Physician]					
	l <sup>-</sup>	fied with new orders to					
		obtain stat x-ray to verify					
	placement noted	. <b>.</b>					
	Between 12:45 j	o.m. on 5/24/2012 and					
	11:23 a.m. on 5/	25/2012, the n/g tube was					
	removed and rep	placed 3 more times due					
	to difficulty in e	nsuring the tube was					
	positioned corre	ctly. At 11:23 a.m.,					
	because the resid	dent was complaining of					
	pain to head and	l neck, the physician gave					
	a new order for	the resident to be sent to					
	the ER for verifi	ication of tube placement.					
	While in the ER	, the n/g tube had been					
	removed and rep	placed again to attain					
	proper placemer	nt.					
	- "5/28/2012 at 9	9:41 p.m Resident					
	removed NG tul	be out of Nare [nose].					
	This writer notif	fied MD, N/O [new order]					
	Re-insert NG tu	be. N/O obtain x-ray via					
	[name of x-ray of	company] to verify					
	placement befor	e resuming meds and					
	feedings stat [im	nmediately]"					
	- "5/30/2012 at 6	6:01 p.m Upon entering					
		om, resident had pulled					
	` ′	nose, notified MD of					
		y via [name of x-ray					
	·	rify placement of NG tube					
	1 23	G tube per policy"					
		- ···· · · · · · · · · · · · · · · · ·					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PWVR11

Facility ID: 000059

If continuation sheet Page 16 of 34

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155697	B. WIN			09/18/	2012
NAME OF F	PROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP CODE		
					ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	AND SKILLED NURSING CENTE	₹	CLARK	SVILLE, IN 47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		6:55 a.m., the resident					
	was transferred to the [specialist						
	physician] cente	r for placement of a					
	g/tube.						
	During an interv	riew with LPN #2 on					
	9/17/2012 at 1:2	0 p.m. and again at 2:40					
	p.m., she indicat	ted there were concerns					
	_	resident back with an NG					
	_	concerned that due to the					
		itia, she might pull it out.					
		8 17					
	Documentation :	was lacking of a care plan					
		I the use of the NG tube					
		s the facility had with its					
		resident's nose and her					
	_						
	frequent remova	11 01 11.					
	2 D	.1					
		e clinical record for					
		9/17/2012 at 3:50 p.m.,					
		e resident was re-admitted					
	to the facility on						
	•	included, but were not					
	limited to: end s	tage renal disease,					
	diabetes mellitus	s, dialysis, and renal					
	failure.						
	Review of the m	ursing notes and physician					
		5/1/2012 and 9/17/2012,					
		placed on 1500 cc [cubic					
		d restrictions on 3					
	_	ons - 5/25 to 6/15/2012					
	when the resider	nt went to the hospital, on					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PWVR11

Facility ID: 000059

If continuation sheet Page 17 of 34

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLI	
		155697	B. WIN	IG		09/18/2	2012
NAME OF P	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP CODE		
CLARK F	REHABILITATION A	AND SKILLED NURSING CENTE	:R		ITTLE LEAGUE BLVD SVILLE, IN 47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		when the resident went					
	-	and on 9/12/2012 until					
	present time.						
	Review of the o	are plans for these time					
		locate a care plan which					
		sident's fluid restrictions.					
		zzzzzz z zzwie z wielenomo.					
	On 8/14/2012, tl	he resident returned from					
	· ·	n new orders for dialysis 3					
	times a week.	·					
	Review of the 8	/14/2012 Admission Care					
	Plan failed to ch	eck off the additional					
	interventions lis	ted for possible inclusion					
	in the care of a c	dialysis resident. Among					
	the additional in	terventions listed for					
	possible inclusion	on were: "Assess dialysis					
	shunt every shif	t. Monitor bruit and thrill.					
	No B/P [blood p	oressure] or venipunctures					
		alysis clinic phone					
		are plan with the missing					
		ventions remained in					
	_	s until a new one had					
	been written.						
	During an inta-	vious with the Minimum					
	Data Set [MDS]	view with the Minimum					
		35 a.m., she indicated					
		dent was first admitted, a					
		plan would be developed,					
		neir assessment, a master					
		be developed to replace					
	the temporary of						
	l temporary of						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PWVR11

Facility ID: 000059

If continuation sheet Page 18 of 34

PRINTED: 10/17/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155697	B. WIN			09/18/	2012
NAME OF P	PROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP CODE		
		ND SKILLED NILIDSING CENTER	,		ITTLE LEAGUE BLVD		
		ND SKILLED NURSING CENTER			SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	COMPLETION DATE
IAG	REGULATORT OR	ESC IDENTIF TING INFORMATION)	+	IAG	,		DATE
	On 0/18/2012 at	2:45 p.m., the Nurse					
		ented a copy of the					
	•	policy on "Care Plan					
	_	ntenance". Review of this					
		e, included but was not					
		cy: It is the policy of this					
		resident will have a					
	-	plan developed based on					
		assessment. The care plan					
	•	surable goals and					
		interventions based on					
	•	nd preferences to promote					
		hest level of functioning					
		al, nursing, mental and					
	_	eds. Procedure:care					
		oals and interventions					
		pased on changes in					
	_	ent/condition, resident					
		mily inputCare Plan					
	•	ose: Create an organized					
	_	itine basis with the					
	_	nunicating with families					
		portant information about					
	· ·	nd needs of the resident in					
	_	y. Help develop stronger					
		h families and residents					
	to improve care.						
	to improve cure.						
	She also presente	ed a copy of the facility's					
	current policy or						
		Leview of the policy at					
	_	d, but was not limited to:					
		ensive care plan will be					
	o. 11 compren	Prant Will Go	1				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PWVR11

Facility ID: 000059

If continuation sheet Page 19 of 34

PRINTED: 10/17/2012 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER:  155697		LDING	00	COMPLETED 09/18/2012	
	PROVIDER OR SUPPLIER	.ND SKILLED NURSING CENTER	•	517 N L	DDRESS, CITY, STATE, ZIP CODE ITTLE LEAGUE BLVD SVILLE, IN 47129		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	Hydration Asses [Interdisciplinary resident needs ar necessary by ID	completion of the sment and review by IDT y Team] with specific and preferences as deemed Γ assessment"  is related to Complaint					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PWVR11

Facility ID: 000059

If continuation sheet Page 20 of 34

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE :	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155697	B. WIN			09/18/	2012
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			517 N L	ITTLE LEAGUE BLVD		
		ND SKILLED NURSING CENTER		CLARK	SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0309 SS=D	483.25 PROVIDE CARE/HIGHEST WELL Each resident mu must provide the services to attain practicable physic psychosocial well the comprehensive care. Based on record the facility failed resident's shunt sof skin on a daily. This deficient pradialysis resident condition in a safe Finding includes.  Review of the cli #C on 9/17/2012 that the resident facility on 8/24/2 which included, 100 median services are serviced in the services of the cli #C on 9/17/2012 that the resident facility on 8/24/2 which included, 100 median services are services as a service of the cli #C on 9/17/2012 that the resident facility on 8/24/2 which included, 100 median services are services as a service of the cli #C on 9/17/2012 that the resident facility on 8/24/2 which included, 100 median services are services as a service of the cli #C on 9/17/2012 that the resident facility on 8/24/2 which included, 100 median services are services as a service of the cli #C on 9/17/2012 that the resident facility on 8/24/2 which included, 100 median services are services as a service of the services are services as a services are services as a	/SERVICES FOR BEING Ist receive and the facility necessary care and or maintain the highest cal, mental, and -being, in accordance with we assessment and plan of review and interviews, It to assess a dialysis site for pain and condition by basis (Resident #C). actice affected 1 of 1 reviewed for shunt site mple of 6 residents.  inical record for Resident at 3:50 p.m., indicated was re-admitted to the 2012 with diagnoses but were not limited to: lisease, diabetes mellitus,	F03	TAG	What corrective actions will be accomplished for those resider found to have been affected by the alleged deficient practice. Resident C's is assess daily for pain and condition of related to dialysis siteassessments are documen in the medical record How other residents have the potential to affected by the same deficient practice will be identified and what corrective actions will be taken All residents recieving dialysis have the potential to affected by the alleged deficient practice Licensed nurses will be educated on assessing a dialy residents access site for pain a skin condition on a daily basis and documenting on the MAR and/or dialysis flow sheet by the	nts / sed skin ted or be	10/12/2012
	On 8/14/2012, the hospital with	ne resident returned from new orders for dialysis 3 d had a shunt placed in			SDC/designee no later than 10/10/12. Post test includedDialysis assessments be monitored daily by the char nurse to ensure assessment o site is documented daily.Non-compliance with the practices will result in further	ge f	
		12 through 9/17/2012 ninistration Records			education including disciplinary action.The Director of	y	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PWVR11

Facility ID: 000059

If continuation sheet Page 21 of 34

PRINTED: 10/17/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER.	(X2) MULTIPLE CONSTRUCTION	<u> </u>	(X3) DATE SURVEY	
AND PLAN		A. BUILDING 00			
	15509/	B. WING		12012	
AND PLAN	PROVIDER OF CORRECTION  TO F CORRECTION  TO F CORRECTION  TO CORRE	A. BUILDING B. WING  STREET ADDRESS, CITY, ST 517 N LITTLE LEAGU CLARKSVILLE, IN 471  ID PREFIX TAG  Nursing/desig to ensure con measures will what systemic made to ensu practice does nurses will be assessing a d residents acc skin condition and documen and/or dialysi SDC/designe	TATE, ZIP CODE  E BLVD 129  SPLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFFICIENCY)  Innee is responsible Inpliance. What I be put into place or c changes will be are that the deficient into recurLicensed e educated on dialysis ess site for pain and in on a daily basis atting on the MAR s flow sheet by the e no later than		
	Consultant presented a copy of the	and/or dialysis SDC/designed 10/10/12. PolincludedDialy be monitored nurse to ensure site is documed daily. Non-compractices will education incompractices will education. The Dimensional Nursing/design to ensure concorrective act monitored to expractice will inquality assurate put into place for dialysis canced weekly x4 monitored and quarterly from the CQI reviewed morplan will be in	s flow sheet by the e no later than st test sis assessments will daily by the charge are assessment of neted appliance with these result in further luding disciplinary rector of gnee is responsible appliance. How the cions will be ensure the deficient not recur, i.e., what cance program will be are will be utilized bothly x 6 thereafter. Findings process will be anthly and an action applemented as any deficient practices		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PWVR11

Facility ID: 000059

If continuation sheet

Page 22 of 34

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETE			ETED	
		155697	B. WIN			09/18/	2012
			D. (//11)		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	L			LITTLE LEAGUE BLVD		
CLARK R	REHABILITATION A	ND SKILLED NURSING CENTER		CLARKSVILLE, IN 47129			
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
F0319 SS=D	483.25(f)(1) TX/SVC FOR ME DIFFICULTIES	NTAL/PSYCHOSOCIAL					
		nprehensive assessment of					
		cility must ensure that a					
	resident who disp						
		ustment difficulty receives					
	correct the asses	•		319			
	Based on record	review and interview, the	F03	19	What corrective actions will be	;	10/12/2012
	facility failed to	ensure a resident who			accompliashed for those		
	was experiencing	g difficulty in adjusting to			residnets found to have been		
	nursing home pla	acement, including			affected by the alleged deficient practice?Resident "E" care pla		
	thoughts of dyin	g and auditory			has been updated to reflect		
	hallucinations, re	eceived appropriate			adjustment issues with		
	-	rvices to help with			interventions including psych		
		nent. (Resident #E). This			services visit and incorporation		
		e affected 1 of 1 newly			previous activity interests. So services has met with resident		
	•	t reviewed for adjustment			to assist resident in adjustmen		
		•			facilityHow will you identify oth		
	in a sample of 6 Findings include				residents having the potential to be affected by the same deficient practice and what corrective		
					action will be taken.Residents		
	Review of the cl	inical record for Resident			experiencing behaviors at the		
	#E on 9/18/2012	at 9:45 a.m., indicated			facility have the potential to be affected by the alleged deficient		
		admitted to the facility			practice. All staff will be		
		rsing home on 8/4/2012			re-educated on the facility		
		es which included, but			behavior program including ho	w	
	_	to: vascular dementia			to appropriately communicate	// 0	
		of mood and behavior,			regarding a behavior by 10/10.	/12	
					by SSD/designee.Post test included.What measures will be	ne l	
	-	rithout agoraphobia,			put into place or what systemic		
		omy tube placement,			changes you will make to ensu		
	dysphagia and he	emipiegia.			that the deficinet practice does		
					not recur?All staff will be		
		irsing notes between	1		re-educated on the facility		
	8/4/2012 and 9/1	8/2012 indicated the	1		behavior program including ho	W	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PWVR11

Facility ID: 000059

If continuation sheet Page 23 of 34

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE SU		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	00	COMPLE	ΓED
		155697	B. WING	-		09/18/2	012
				STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				ITTLE LEAGUE BLVD		
		ND SKILLED NURSING CENTER			SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	following entries	3:			to appropriately communicate		
	- "8/8/2012 at 10	:00 a.m Res (resident)			reagarding a behavior by		
	became very tearful this am crying loudly				10/10/12 by the SSD/designee.Residents with		
		aughter saying 'I want out			behavioral issues will have a c		
		n't what I though it was			plan developed with the		
	going to be'"	i vinut i mough it was			interventions to assist in		
	going to be				managing the behavioral		
	110/0/0010				issue.New or worsening		
		06 p.mNot as tearful			behaviors will be reviewed by	the	
	today"				IDT Monday through Friday,		
					weekends will call the on-call		
	- "8/14/2012 at 6	:45 p.m Res in room			nurse to assess cause, and update interventions to decrea	180	
		g she was going to die.			cause.IDT reviews will include		
		tunnel and she was			assessment of potential medic		
		sured her she wasn't			contributors, root cause and		
		sured her she wash t			preventative intervention.Socia	al	
	going to die"				services will meet with rsidents	S	
					who are having adjustment		
	- "8/23/2012 at 7	:22 a.m Res abed.			difficulties and develop		
	Sleeping most of	shift. When res woke			interventions to address		
	she up she was v	ery confused. Said she			adjustment.IDT will review interventions and progress to		
	_	nd wanted to know if she			residents adjustment.IDT will		
	· ·	. I assured her she was			review changes (including new	v or	
		She also was stating her			worsening) for need to addres		
		<del>-</del>			advanced directive wishes.		
	-	arms. She was then			Social services/designee will		
	_	ckey Mouse doll beside			inform families of behavior		
		he told him to shut up. I			changes or changes in condition		
		key was talking to her			IDT will ensure that notification	n is	
	and she said yes	that he said he was in			complete per medical record review. Residents/families wil	l he	
	pain too"				contacted by social services	וטכ	
	•				director or designee for a care		
	Review of the So	ocial Service			plan meeting to address. Soci		
		etween 8/4/2012 and			services/designee respnsible f		
					complianceNon-compliance w	ill	
	9/18/2012 indica				result in re-education includior	ng	
	8/10/2012 which	addressed an Admission			disciplinary actionHow the		
	Assessment on the	ne resident's cognition,			corrective actions will be		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155697	B. WIN	IG		09/18/2012	
NAME OF B	DOWNER OF CLIPPLIED		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			517 N L	ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	ND SKILLED NURSING CENTER	₹	CLARK	SVILLE, IN 47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG		5.112	
		communication skills and			monitored to ensure the deficient practice will recur, e., what quant		
	discharge plan. I	t also addressed the			assurance program will be put	-	
	resident was to b	be seen by the psychiatrist			into place The Psychoactive		
	next visit to man	age psychiatric diagnoses			Medications/Behavior		
	and medications				management CQI tool will be		
					utilized weeklyx4, then monthly	y	
	A second note da	ated 8/15/2012 indicated			thereafter by the SSD or designee for six months. Data		
	the resident was	evaluated by the			will be submitted tot he CQI		
		nis date per staff and			committee for review and		
		st due to poor appetite and			follow-upThe care plan review		
	tearfulness at tin				CQI audit tool will be utilized		
	vewiteriness we thin				weekly x4, then monthly thereafter by the SSD or		
	Documentation s	was lacking in which the			designee for six months. Data		
		ddressed the resident's			will be submitted tot he CQI		
					committee for review and		
	_	djusting to placement,			follow-upFindings from the CQ		
	thoughts of dyin	g and auditory			process will be reviewed mont	hly	
	hallucinations.				and an action plan will be implemented for threshold belo	NA.	
					95%.	,	
	_	iew with the Social					
		2012 at 4:25 p.m., she					
		s not aware the resident					
		tements of thinking she					
	J 0,	djusting to placement,					
	and the episode	of auditory hallucination					
	as she would hav	ve addressed the issues as					
	well as making s	sure the psychiatrist was					
	also aware.						
	She indicated that	at she usually she would					
		orning meetings if the					
		aving issues and that the					
		out behavior sheets					
		ue like the statements of					
		out that she had put into					
	aying occurred t	out that she had put into	1				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PWVR11

Facility ID: 000059

If continuation sheet

Page 25 of 34

PRINTED: 10/17/2012 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number:  155697	(X2) MULTIPLE CONST.  A. BUILDING B. WING	00	COMPLETED 09/18/2012
	PROVIDER OR SUPPLIER REHABILITATION AND SKILLED NURSING CENTER	517 N LITT	RESS, CITY, STATE, ZIP CODE LE LEAGUE BLVD LLE, IN 47129	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	place a new system in the computer at the end of August for Behavior Monitoring in which the staff enter an event occurrence, and then it would create a report she could review every morning. The Social Worker also indicated that because the staff were still trying to get used to her new system, she was still not always getting reports of issues.  This Federal tag is related to Complaint IN00115675.  3.1-43(a)(1)			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PWVR11

Facility ID: 000059

If continuation sheet

Page 26 of 34

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155697	B. WIN			09/18/	2012
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ITTLE LEAGUE BLVD		
CLARK R	PEHARII ITATION A	ND SKILLED NURSING CENTER			SVILLE, IN 47129		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0322	483.25(g)(2)						
SS=D		/SERVICES - RESTORE					
	EATING SKILLS	anrahansiya assassment of					
		nprehensive assessment of cility must ensure that a					
		ed by a naso-gastric or					
		receives the appropriate					
		vices to prevent aspiration					
		nea, vomiting, dehydration,					
	metabolic abnorm	nalities, and					
		ulcers and to restore, if					
	possible, normal	eating skills.					
	Based on record	review and interviews,	F03	22	What corrective actions will be		10/12/2012
	the facility failed	I to assess a resident who			accomplished for those reside		
	had confusion an	nd an NG tube for			found to have been affected by	•	
		of placement and ability			the deficient practiceResident	A	
		ent's needs (Resident			no longer has an N/G tube-		
		•			resident has a g-tube and has been assessed for		
	*	ent practice affected 1 of			appropriateness of placement		
		wed for feeding tubes in a			and ability to meet residents		
	sample of 6 resid	lents.			needs.How other residents		
					having the potential to be affect	cted	
	Finding includes	:			by the same deficient practice		
					be identified and what corrective		
					actions will be takenAll resider	nts	
	Review of the al	inical record for Resident			with an enteral tube and	ho	
					dementia have the potential to affected by the alleged deficier		
		at 11:10 a.m. indicated			practice- Licensed nurses will		
		re-admitted from the			re-educated on assessing		
	-	2012 and had diagnoses			residents with dementia and a	n	
	which included,	but were not limited to:			enteral feeding for		
	dysphagia, diver	ticulosis and dementia.			appropriateness and ability to		
					meet residents needs by the		
	Review of the M	ay 2012 nursing notes			SDC/designee on or before	: _	
		re not limited to the			10/10/12. Post test included.If		
	*				resident is admissted with a n/ tube the DNS/designee will	y	
	following entries				ensure residents are assessed	1	
		50 p.m Res discharged			for acceptance of n/g tube and		
	to [name of hosp	oital] for g-tube			appropriate placement by		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PWVR11

Facility ID: 000059

If continuation sheet Page 27 of 34

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MI	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріш	DING	00	COMPLETED
		155697	A. BUILDING 09/18/2012			
			B. WIN		ADDRESS CITY STATE ZID CODE	
NAME OF P	ROVIDER OR SUPPLIER	₹		1	ADDRESS, CITY, STATE, ZIP CODE	
					ITTLE LEAGUE BLVD	
CLARK F	REHABILITATION A	AND SKILLED NURSING CENTER		CLARK	SVILLE, IN 47129	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	placement."				monitoring the resident and	
	1				reviewing the medical record a	ıs
	"5/4/2012 of 4.	41 mm mt [matiant]			needed.Non compliance with	
		41 p.m pt [patient]			practices will result in further	
		l new g-tube out of			education including disciplinar	У
	_	hift and site was bulging			actionDNSdesignee is	-4
	and reddenedN	MD notified and family			responsible for complianceWh	
	notified and pt se	ent to [name of hospital]			measures will be put into place what systemic changes will be	<del>,</del> 01
	ER [emergency ]	room] for evaluation of			made to ensure that the deficie	ent ent
	site and placeme	=			practice does not recurLicense	
	Site and placeme				nurses will be re-educated on	.~
	mi i	1 1 1 1 1 1			assessing residents with	
		s subsequently admitted			dementia and an enteral feedi	ng
	to the hospital u	ntil 5/18/2012 when she			for appropriateness and ability	to
	returned with an	n/g tube [nasogastric].			meet residents needs by the	
					SDC/designee. on or before	
	- "5/19/12 at 2·3	5 p.m Resident			10/10/12. Post test included.lf	-
		pe at 1300 [1:00 p.m.].			resident is admissted with a n/	9
					tube the DNS/designee will	1
		ved to replace NG tube			ensure residents are assessed for acceptance of n/g tube and	•
	with chest x-ray	•			appropriate placement by	
	placementResi	ident tolerated procedure			monitoring the resident and	
	well"				reviewing the medical record a	ıs
					needed.Non compliance with	
	_ "5/19/2012 at 7	7:27 p.m Res resting in			practices will result in further	
		esults from x-ray. Showed			education including disciplinar	y
		•			actionDNSdesignee is	
		each. Went to give res			responsible for complianceHov	N
	•	d meds. Res had pulled			the corrective actions will be	
	NG tube out. Sta	ated 'I don't want that in.'			monitored to ensure the deficie	
	Res agitated at	t this time. Not allowing			practice will not recur, i.e., what quality assurance program will	
	_	tube. Will attempt when			put into placeThe CQI audit to	
	res calms down.	•			for enteral therapy will be utilize	
	100 canno down.				weekly x4, monthly x6 and	
	115/04/0010	11 20 5 11 1			quarterly thereafter.Findings fr	om
		11:30 a.m Res. pulled			the CQI process will be review	
	-	Name of Physician]			monthly and an action plan wil	
	phoned and notif	fied with new orders to			implemented for threshold belo	ow
	replace n/g and o	obtain stat x-ray to verify			95%The CQI audit tool for ente	eral

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PWVR11

Facility ID: 000059

If continuation sheet Page 28 of 34

PRINTED: 10/17/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:  155697	A. BUII B. WIN	LDING	00	COMPL 09/18/	ETED
	PROVIDER OR SUPPLIER	ND SKILLED NURSING CENTER		517 N L	ADDRESS, CITY, STATE, ZIP CODE ITTLE LEAGUE BLVD SVILLE, IN 47129		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)	TE	(X5) COMPLETION DATE
	11:23 a.m. on 5/2 removed and rep to difficulty in er positioned correct because the reside pain to head and a new order for the ER for verification while in the ER, removed and repproper placement - "5/28/2012 at 9 removed NG tub This writer notification Re-insert NG tub [name of x-ray coplacement before feedings stat [immage of the company] to verification of the company] to verification of the company of	a.m. on 5/24/2012 and 25/2012, the n/g tube was laced 3 more times due assuring the tube was etly. At 11:23 a.m., lent was complaining of neck, the physician gave the resident to be sent to cation of tube placement. the n/g tube had been laced again to attain t.  :41 p.m Resident e out of Nare [nose]. led MD, N/O [new order] be. N/O obtain x-ray via company] to verify e resuming meds and mediately]"  :01 p.m Upon entering om, resident had pulled ose, notified MD of via [name of x-ray ify placement of NG tube it tube per policy"			feeding		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PWVR11

Facility ID: 000059

If continuation sheet Page 29 of 34

PRINTED: 10/17/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:  155697	A. BUILDING  B. WING			COMPL: 09/18/	ETED
	ROVIDER OR SUPPLIER	ND SKILLED NURSING CENTER	J. WIIV	STREET A	ADDRESS, CITY, STATE, ZIP CODE ITTLE LEAGUE BLVD SVILLE, IN 47129		
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
	9/17/2012 at 12:0 resident would of when referring to she thought this is reason for the resident young an interviry 9/17/2012 at 1:20 p.m., she indicate about taking the tube as I was contresident's dementand not leave it is something normal Administrator an aware of my contract.	al, felt weird to her. My d Nurse Consultant were					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PWVR11

1

Facility ID: 000059

If continuation sheet

Page 30 of 34

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155697	B. WIN			09/18/	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				LITTLE LEAGUE BLVD		
CLARK R	REHABILITATION A	ND SKILLED NURSING CENTER			SVILLE, IN 47129		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0514	483.75(I)(1)						
SS=D	RES						
		PLETE/ACCURATE/ACCE					
	SSIBLE	maintain aliniaal racarda an					
	_	maintain clinical records on accordance with accepted					
		dards and practices that					
	-	curately documented;					
		e; and systematically					
	organized.						
		d must contain sufficient					
		ntify the resident; a record					
		assessments; the plan of a provided; the results of					
		s screening conducted by					
	the State; and pro	•					
	· ·	review and interview, the	F05	14	What corrective actions will be		10/12/2012
		accurately document one			accomplished for those reside		
	_	dosage and start date of			found to ha ve been affected b	•	
		e monthly physician			the deficient practiceResident		
		physician signed them			did not have a negative outcor related to the alleged deficiant		
		nd accurately document			practice. Resident E's medical		
	one resident's ord	-			record is up to date designatin		
		e Nutritional Risk			the correct start date and dosa	-	
					of coumadinResident C's dieta	,	
		dietary progress notes			progress notes/ nutritional risk assessment have been updat		
	` ′	his deficient practice			to reflect resident's current	Cu	
		esidents reviewed for	1		condition relateing to fluid		
	-	elinical records in a			restrictions.How other resident		
	sample of 6 resid	lents.			having the potential to be affect		
					by the same deficient practice		
	Findings include	d:			be identified and what correcting actions will be takenAll resider		
					have the potential to be affected		
					by the alleged deficient		
	1. Review of the	clinical record for			practicesLicensed nurses		
		0/18/2012 at 9:45 a.m.,			completing monthly Re-writes	will	
		ident was admitted to the			be inserviced on completing		
	maicated the resi	ident was admitted to the			accurately to reflect residents		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PWVR11

Facility ID: 000059

If continuation sheet Page 31 of 34

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPLE	ETED
		155697	A. BUII B. WIN			09/18/2012	
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	L.					
		ND SKILLED NUDSING CENTED			ITTLE LEAGUE BLVD SVILLE, IN 47129		
CLARK	REHABILITATION A	ND SKILLED NURSING CENTER		CLARK	SVILLE, IN 47 129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	facility from and	ther nursing home on			current plan of care,		
	8/4/2012 and had	d diagnoses which			matched against any new	.	
		re not limited to: vascular			telephone or new orders recie	ved	
	-	sturbance of mood and			in the last month and any	ad	
					discontinued order to be cross out with a single line, initialed a		
	behavior, panic				dated as well as yellowed out		
	,	xiety, gastrostomy tube			the SDC/designee on or before	-	
	placement, dyspl	hagia and hemiplegia.			10/10/12. Post test		
					included.Licensed nurses and		
	Review of the Se	eptember 2012 Monthly			dietary employees will be		
	Physician Orders	s (re-writes) indicated the			in-serviced on communication		
		hecked by LPN #2 on			system for dietary changes by	the	
		gned off as "correct".			DNS/designee on or before		
		_			10/10/12. Post test included. A final check for re-writes will be		
	_	writes included an order			completed by the charge nurse		
	`	blood thinner) 3 mg			on night shift the night of chan		
	[milligrams] - ta	ke 1 tablet per g-tube			over to ensure orders are		
	[gastrostomy] or	nce daily with an order			accurate.100% audit of dietary	,	
	date of 8/4/2012	. The monthly re-writes			progress notes and nutritional	risk	
	were also then si	gned by the physician on			assessments for residents on		
	9/6/2012.				fluid restriction will be reviewed	d	
	<i>y, 0, 2012.</i>				to ensure accuracy.All dietary	_	
	Di £41 4-	lankana andana indiastad			changes will be reviewed in the		
		lephone orders indicated			clinical meeting by the IDT. And dietary changes will be	i iy	
		umadin had been			communicated to dietary using	,	
	discontinued on	8/11/2012 and not			the dietary communication	'	
	re-started until 9	/2/2012 with a new order			form.Non-compliance with		
	for Coumadin 2	mg po [by mouth] Q			procedures will result in furthe	r	
	[daily] at 5 p.m.				education including disciplinar	y	
					actionThe DNS/designess is	_ l	
	During an interv	iew on 9/18/2012 at 4:30			responsible for compliance.Wh		
	_				measures will be put into place		
	_	dicated the next month's			what systemic changes will be made to ensure that the deficie		
		tes were supposed to be			practice does not recurLicense		
	matched against	any telephone or new			nurses completing monthly		
	orders received i	n the last month.			Re-writes will be inserviced on		
					completing accurately to reflect		
	On 9/18/2012 at	3:30 p.m., the Nurse			residents current plan of care,		
		P,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PWVR11

Facility ID: 000059

If continuation sheet Page 32 of 34

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED	
		155697	A. BUI B. WIN	ILDING		09/18/	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			LITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	AND SKILLED NURSING CENTE	R		SVILLE, IN 47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		ented a copy of the			matched against any new		
	_	• •			telephone or new orders recie	ved	
	1	policy on "Reviewing			in the last month and any		
		The Physician's Re-Write			discontinued order to be cross	ed	
	Forms, Medicati	ion And Treatment			out with a single line, initialed		
	Records". Revie	w of this policy at this			dated as well as yellowed out		
	time included, b	ut was not limited to:			the SDC/designee on or befor	е	
	"Procedure: Upo	on receipt of the monthly			10/10/12. Post test		
	•	inistration records and the			included.Licensed nurses and dietary staff will be in-serviced		
		sheets, the nurse shall			communication system for die		
					changes by the DNS/designed	,	
		t each residents' record for			or before 10/10/12. Post test		
accuracy and make any necessary				included.A final check for			
	corrections. It is important that these				re-writes will be completed by		
	directions are fo	llowed when correcting			charge nurse on night shift the		
	the physician's o	order sheet and medication			night of change over to ensure		
	administration, a	and treatment			orders are accurate.100% aud	IIT	
	1	d and date each page			of dietary progress notes and nutritional risk assessments b	, t	
	1	rite "D/C" at the end of			he RD/designee for residents		
	the order and en				fluid restrictions will be review		
					to ensure accuracy.All dietary		
	initials/signature	<b></b> .''			changes will be reviewed in th	е	
					clinical meeting by the IDT. A	ny	
					dietary changes will be		
	2. Review of the	clinical record for			communicated to dietary using	)	
	Resident #C on	9/17/2012 at 3:50 p.m.,			the dietary communication form.Non-compliance with		
		e resident was re-admitted			procedures will result in furthe	r	
	to the facility on	8/24/2012 with			education including disciplinar		
	1	included, but were not			actionThe DNS/designess is	,	
		·			responsible for compliance.Ho	w	
		tage renal disease,			the corrective actions will be		
		s, dialysis, and renal			monitored to ensure the defici		
	failure.				practice will not recur, i.e., wh		
					quality assurance program wil		
	Review of the 9/	/1/2012 Nutrition Risk			put into place. The CQI audit to for pharmacy services will be	וטנ	
	Assessment indi	cated the resident was on			utilized weekly x4, monthly x6	and	
	fluid restrictions	of 1500 cc [cubic			quarterly thereafter. The CQI to		
		day. A 9/1/2012 at 8:22			dietician recommendations wi		
	continueters   per	auj. 11 // 1/2012 at 0.22			1		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PWVR11

Facility ID: 000059

If continuation sheet

Page 33 of 34

PRINTED: 10/17/2012 FORM APPROVED OMB NO. 0938-0391

			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155697	B. WIN	IG		09/18/2012
NAME OF I	DROVIDED OD GUDDU IED			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF	PROVIDER OR SUPPLIER			517 N L	ITTLE LEAGUE BLVD	
		ND SKILLED NURSING CENTE	R		SVILLE, IN 47129	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	` `	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG		DATE
		te by dietary also			utilized weekly x4, monthly x6 quarterly thereafter.Findings fr	
		ident was receiving 1500			the CQI process will be review	
	ml [milliliters] fl	luid restriction per day			monthly and an action plan	
	due to DM [diab	etes], renal insuff			implemented for threshold belo	ow
	[insufficiency] a	nd HTN [hypertension].			95%	
	On 8/24/2012, re	eview of the re-admission				
	orders from the l	hospital to the facility				
	failed to locate a	n order for the resident to				
	be on fluid restri	ctions.				
	The Nutrition R	isk Assessment and				
		ere not corrected until				
		he Consultant Dietitian				
	completed a new					
	-	ch reflected that she had				
		nurse that the fluid				
	restrictions had t	been discontinued.				
	This Federal tag	is related to Complaint				
	IN00115675.	is related to Complaint				
	11100113073.					
	2.1.50(-)(2)					
	3.1-50(a)(2)					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PWVR11

Facility ID: 000059

If continuation sheet Page 34 of 34